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Response to RFI
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Organizational Overview

Community & Home Supports (CHS) is a 501 [c] 3 nonprofit organization providing home-based services to individuals and families in crisis. CHS services focus on building strong communities by providing programs that 1) increase skills that enable individuals and families to achieve greater self-sufficiency and 2) strengthen their capacity to deal independently with future challenges. CHS staff has extensive experience in providing comprehensive supportive services to individuals and families in the Cities of Detroit, Highland Park and Hamtramck that are homeless or at-risk of becoming homeless.

CHS has been successful in assisting individuals and families in obtaining and maintaining safe, affordable housing. Staff experience includes navigating local, state and federal resources such as the Department of Human Resources, Social Security and Disability, Medicaid, Medicare and Community Mental Health, Substance Abuse, Criminal and Juvenile Justice, Adult Care Services, and assisting families in addressing other complex barriers. Combined staff experience and long-term, trusting relationships with reliable local landlords has provided rapid access to safe and affordable housing in the community to individuals and families. This past year CHS has provided services (case management, prevention, rapid re-housing, job development, and leasing assistance) to 401 households with a success rate of 73% in positive permanent and stable housing placements with sufficient income. These successful permanent housing placements have resulted in those individuals and families becoming self-sufficient and independent.

CHS utilizes the principles of the Housing First Model of service delivery. Through this model CHS is able to more efficiently provide preventative services or suitable housing to individuals in immediate need. This is followed by intensive home-based services designed to ensure that families can maintain housing. This service model helps to alleviate strain on the local emergency shelter system and reduces interruption for families in employment, education and other areas of their lives.

By providing intensive in-home case management services and targeted outreach CHS has assisted individuals and families with removing barriers thus increasing success rates for maintaining permanent housing in the community. Utilizing the principles of trauma-informed, strength-based case management and person-centered planning we have been able to assist individuals and families in identifying their needs, strengths and barriers to permanent housing. This process encourages individuals and families to address short-term barriers, rebuild a sense of efficacy and personal control over their lives, while at the same time working toward their goal of permanent housing. It also encourages the consideration of exposure to forms of trauma that led to homelessness that must be addressed during the “recovery” to stability. This process ensures that people remain motivated and engaged in creating long-term stability through participation in supportive services. Supports such as:

- financial literacy,
- job development,
- legal services,
- child care,
- substance abuse assessment/referral,
- Life Skills training, and
- coordinating/linking to mainstream resources in physical/mental health and counseling

play a key role in providing people with the knowledge and skills necessary to maintain safe and affordable housing, increase their income and/or skills and lead self-determined lives in the community. CHS services emphasizes safety and works towards building physical and

emotional safety for clients by being aware of the potential triggers for the client and striving to avoid retraumatization.

A key component to CHS' services is the cultivation of relationships with reliable landlords and other service providers. CHS has a network of over 300 landlords in the area that are willing to work with individuals and families who are experiencing homelessness. These networks allow CHS to mobilize resources and services more efficiently for individuals and families in crisis.

Priority Areas

Generally, low incomes and high housing costs, combined with a lack of supportive services for those who need them, make many people vulnerable to homelessness. Four major populations at increased risk of homelessness are people living in "doubled up" situations, people discharged from prison, young adults leaving foster care, and people without health insurance. Within each of these populations is an increased prerequisite to focus on the needs of women and children who are homeless and have repeated homelessness as a result of trauma.

The "doubled up" population (people who live with friends, family or other nonrelatives for economic reasons) increased nationally by 13 percent from 6 million in 2009 to 6.8 million in 2010. People recently released from prison, and young adults who have recently been emancipated from the foster care system (aged out) are also at increased risk of homelessness. In Michigan the current statistics show that 1 in 5 or more of the aging out foster care youth will become homeless after age 18. Seven of 10 young women will be pregnant by their 21st birthday. Just half will be employed at 24. Fewer than 3% will earn a college degree by 25. 1 in 4 will be incarcerated within two years of leaving foster care.

The odds for a person in the general U.S. population of experiencing homelessness in the course of a year are 1 in 194. For an individual living doubled up the odds are 1 in 12. For a released prisoner they are 1 in 13. The number of people without health insurance increased nationally by 4 percent from 47.2 million in 2009 to 48.8 million in 2010. Nationally, 1 out of every 6 people is uninsured.

In addition to this data from The National Alliance to End Homelessness, data from homeless shelters in the City of Detroit and SAMSHA discuss states" the overwhelming percentage of homeless individuals, families and children have been exposed to additional forms of trauma including neglect, psychological and physical abuse, sexual abuse during childhood, community violence, combat-related trauma, domestic violence, underemployment, mental illness, prison, foster care experience, accidents, and disasters. that have rendered them homeless. Therefore, placing individuals/families as quickly as possible in permanent housing, and providing intensive home-based case management and stabilizing support services based on the uniqueness of each groups' specific needs reduces the recurrence of homelessness and increases the capability of more stable communities.

Technical Requirements

A. *Availability of performance measures for assessing outcomes.*

As we look at the four populations identified the development successful performance and measureable outcomes that define success must begin with a complete assessment of the

individuals/families involved including safety assessments that ask about boundary violations and abuse of power experienced by the client. Issues and circumstances that brought the individual/family to the "doorstep of need" are identified in a thorough assessment (biopsychosocial in order to build wraparound services that address physical and emotional safety for both the client and the provider. Additionally, developing progressive case management systems that begin intensively and "ratchet down" as the client no longer requires the support in order to maintain stability are imperative to demonstrate measurable successes. This process also allows for clients to be referred within a network of coordinated and collaborative services that are working together to track progress and needs. The system relies on "coordinated" case conferencing of service providers meeting to review difficult cases. "Coordinated Care", similar to a medical model for those in intensive care, on life support, diagnosed with stage 5 illnesses must be in place when clients face what could be called "Stage 5 homelessness" – evidence of unstable, critical, life threatening housing and emotional supports.

How do we *measure successful outcomes* for the identified populations?

1. ***"doubled up" population*** – successfully in transitional housing within 6 months or permanent housing within 1 year with budget and income to sustain independence and housing.

2. people ***discharged from prison*** – successfully employed and in transitional/permanent housing within 3 – 6 months of release with no new criminal charges.

3. ***young adults leaving foster care*** – successfully living in transitional/permanent housing within 30 days of leaving foster with on-going financial supports through YAVFC program as appropriate, Employment, and/or College Financial Aid and other entitlements.

4. ***people without health insurance*** – successfully link clients to health care plans and community-based clinics (where appropriate). Link clients with World Health Organization and other low/no cost prescription programs for on-going medication needs. Provide monitoring/follow-up for those with identified health concerns/risks monthly to support on-going engagement in health services.

5. Ongoing educational/vocational supports as appropriate to ensure economic stability with evidence of "current standing/grades" or program completion. Enrollment with CHS Job Development and tracking of employment searches and follow-up.

6. Budget training and monitoring monthly as appropriate to assist individuals in developing and maintaining successful spending/saving habits as evidenced by a savings account verification and proof of monthly obligations paid.

7. Successful completion of Tenant Responsibility/Housing Curriculum within 60 days of entering program/

B. *Strong evidence base indicating the intervention model is likely to achieve the outcome targets*

According to various research reports published in *The Open Health Services and Policy Journal* and through SAMHSA there is very strong evidence of the success of incorporating trauma-informed care and practices into a service delivery system that also utilizes strength-based, person-centered practices. When a service delivery system ensures that it's staff understand the principals and utilizes the practices of upholding the boundaries and power issues that push clients to "stall" in their recovery and stability, it is well documented that clients can move toward successfully taking control of circumstances in their lives with the support of staff.

Therefore, CHS provides staff with initial and on-going training utilizing these practices of service delivery from the point of intake through successful discharge. Screening instruments gather information that will assist staff in developing plans with the clients' input to overcome often innumerable obstacles that they face in the process of exiting homelessness, foster care, and/or the prison system.

Collaborative Partners:

The Executive Director, Director of Programs, Director of Operations & Quality, Intake Coordinators, Housing Case Managers, Job Developer, and Adult Services Manager & staff of CHS are fully prepared and look forward to remaining active contributing members of any and all provider network meetings and activities established to carry out these services.

Collaborations with a variety of community-based providers are already established. Key partners are set forth in Attachment A of this response. Those who partner with CHS participate in on-going collaborative conversations/meetings to discuss and remove barriers to success for clients. Collaborative partners agree that each organizations staff will receive training in the three dynamic areas of services delivery: Trauma-informed care, person-centered planning, and strength-based services

C. *Sufficient and well defined participant base*

The four populations identified in this response are:

- Doubled up population
- Youth aging out of foster care (approximately 2000 children 0-17 in Wayne County)
- Individuals exiting prison
- People without health insurance

with an "embedded" subcategory for each of women/children who are all very well defined and sufficient focus groups. Within the Metropolitan Detroit area 64% of households are single female headed which represents 111,000 households according to Kids Count data.

D. *Ability to take the initiative to scale if results show that the initiative is working*

Currently CHS is a small community based organization; however participates in the larger network of providers in the field. CHS staff have formidable relationships with colleges/universities (Wayne State University, Marygrove College, University of Michigan, Spring Arbor University, University of Phoenix, Michigan State University, Wayne County Community College), the corporate community, Henry Ford Hospital, Detroit Wayne County Community Mental Health Agency, Homeless Action Network of Detroit, and Landlords. This network and the collaborations already in existence make the transition to take this initiative to scale one that is easily achieved because we work with so many partners. This agency has the capacity to build strong ties to provide services to the identified population without excessive barriers.

CHS is growing now and positioning itself to be among the premier agencies of choice here in the Tri-county Metropolitan Detroit area. The young talent combined with the experienced leadership and the Board of Directors support, CHS can provide the services as indicated in this RFI as the program receives appropriate funding.

E. Clear and identifiable state budgetary savings

The number of unduplicated participants to be served in this program is 200. The projected number of case management units to be provided is 13,000 units of service.

Each participant is estimated to utilize 65 units of services over six (6) months in order to demonstrate success and stability in the program. Case Management services include: referring, linking, advocating, coordinating, following-up for provision of services to meet identified needs; includes assisting with paperwork; navigating complex public and private systems such as physical and behavioral health care, entitlements and income maintenance, legal, child custody, education, employment and training programs, identity restoration – birth certificates, Michigan identification, and obtaining other documents such as divorce degrees, child support, alimony, death certificates, foster care and adoption information, temporary and permanent shelter in a welcoming safe, clean, nurturing, empowering and supportive environment.

Clearly the savings to the State is the coordination through a Lead Agency with a history, experience, and success in serving these four distinct populations through linking and coordinating care with follow-up provided in the community. CHS has demonstrated success in assisting individuals and families in maintaining stabilized housing, gaining employment, and improving their skills in budgeting and financial responsibility. These successes reduce the number of individuals who become homeless as a result of health issues caused by stress, unstable living conditions, and financial hardships from underemployment/unemployment and/or lack of education to become employed. Coordinated case management and follow-up in the community assists participants in remaining motivated for change and success.

Increase success rate for participant group through coordination & follow-up through Lead Agency Staff of 80% as a result of monitoring and case conferencing techniques with network of providers. **Total Cost Quote: $200,000.00**

CHS Collaborative Provider Network
2013 - 2014
Current & To Be Enlisted

ATTACHMENT A

SERVICE	PROVIDER
Shelters/Homeless Providers	Homeless Action Network of Detroit (HAND) COTS Interim House Heartline Ruth Ellis NSO Bell Building NSO Tsumani Center Covenant House Detroit Central City CMH – PATH Program Southwest Solutions Off The Streets
Substance Abuse Providers (including residential)	Salvation Army Harbor Light DRMM Elmhurst House Detroit Recovery Project
Health Care Providers/Clinics (Physical/Behavioral)	Covenant Community Care Joy Southfield Clinic Advantage Health Centers (5 locations) Crystal Home Healthcare Detroit Community Health Connection, Inc. BHPI (CareLink/Consumer Link) Detroit Wayne County CMH Agency Children's Center of Wayne County Guidance Center NE Guidance Southwest Solutions New Center CMH